is called transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections, as well as those who lose eligibility due to an increase in earned income or hours of employment. However, Congress expanded work-related TMA under Section 1925 of the Social Security Act in 1988, requiring states to provide at least six, and up to 12, months of coverage. Since 2001, these work-related TMA requirements have been funded by a series of short-term extensions, most recently through June 30, 2009.

To qualify for work-related TMA under Section 1925, a family must have received Medicaid in at least three of the six months preceding the month in which eligibility is lost and have a dependent child in the home. During the initial 6-month period of TMA, states must provide the same benefits the family was receiving, although this requirement may be met by paying a family's premiums, deductibles, coinsurance, and similar costs for employer-based health coverage. An additional 6-month extension of TMA (for a total of up to 12 months) is available for families who continue to have a dependent child in the home, who meet reporting requirements, and whose average gross monthly earnings (less work-related child care costs) are below 185% of the federal poverty line. States may impose a premium, limit the scope of benefits, and use an alternative service delivery system during the second six months of TMA.

HOUSE BILL

The provision would extend work-related TMA under Section 1925 for 18 months through December 31, 2010. The provision also would give States the flexibility to extend an initial eligibility period of 12 months of Medicaid coverage to families transitioning from welfare to work, in which case the additional 6-month extension would not apply. The House bill also gives states the option of waiving the requirement that a family must have received Medicaid in at least three of the last six months in order to qualify.

Under the House provision, states would be required to collect and submit to the Secretary of Health and Human Services (and make publicly available) information on average monthly enrollment and participation rates for adults and children under work-related TMA; states would also be required to collect and submit information on the number and percentage of children who become ineligible for work-related TMA, but who continue to be eligible under another Medicaid eligibility category or who are enrolled in the Children's Health Insurance Program.

SENATE BILL

The Senate bill is the same as the House bill.

CONFERENCE AGREEMENT

The conference agreement follows the House and Senate bills.

SEC. 5005. EXTENSION OF THE QUALIFYING INDIVIDUAL (QI) PROGRAM (SEC. 3201 OF THE SENATE BILL)

CURRENT LAW

Certain low-income individuals who are aged or have disabilities, as defined under the Supplemental Security Income (SSI) program, and who are eligible for Medicare, are also eligible to have their Medicare Part B premiums paid for by Medicaid under the Medicare Savings Program (MSP). Eligible groups include Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs). QMBs have incomes no greater than 100% of the federal poverty level (FPL) and assets no greater than $4,000 for an individual and $6,000 for a couple. SLMBs meet QMB criteria, except that their incomes are greater than 100% of FPL but do not exceed 120% FPL. QIs meet the QMB criteria, except that their income is between 120% and 135% of FPL. Further, they are not otherwise eligible for Medicaid. The QI program is currently slated to terminate December 2009.

In general, Medicaid payments are shared between federal and state governments according to a matching formula. Unlike the QMB and SLMB programs, the QI program is paid 100% by the federal government from the Part B Trust fund. The total amount of federal QI spending is limited each year and allocated among the states. States are required to cover only the number of people that would bring their annual spending on these population groups to their allocation levels. For the period beginning on January 1, 2009 and ending on September 30, 2009, the total allocation amount for all states was $350 million. For the period that begins on October 1, 2009 and ends on December 31, 2009, the total allocation is $150 million.

HOUSE BILL

No provision.

SENATE BILL

This provision would extend the QI program an additional year from December 2009 to December 2010. It establishes specific funding limits:

- from January 1, 2010, through September 30, 2010, the total allocation amount would be $412.5 million, and
- from October 1, 2010, through December 31, 2010, the total allocation amount would be $150 million.

CONFERENCE AGREEMENT

The conference agreement follows the Senate bill.

SEC. 5006(A), (B), (C). PROTECTIONS FOR INDIANS UNDER MEDICAID AND CHIP (SEC. 5004 OF THE HOUSE BILL; SEC. 3301 OF THE SENATE BILL)

CURRENT LAW

Premiums and Cost Sharing. In Medicaid, premiums and enrollment fees generally are prohibited for most beneficiaries. Nominal premiums and enrollment fees specified in regulations may be imposed on selected groups (e.g., medically needy, certain families qualifying for transitional Medicaid, pregnant women and infants with income over 150% FPL). Premiums and enrollment fees can exceed these nominal amounts for other selected groups (e.g., certain workers with disabilities and individuals covered under Section 1115 demonstrations).

Service-related cost-sharing (e.g., deductibles, copayments, co-insurance) is prohibited for selected groups (e.g., children under 18, pregnant women) and for selected benefits (e.g., hospice care, emergency services, family planning services and supplies). For most other groups and services, nominal cost-sharing amounts specified in regulations may be applied at state option. For other selected groups (e.g., workers with disabilities and individuals covered under Section 1115 demonstrations), cost-sharing can exceed nominal amounts.

The Deficit Reduction Act of 2005 (P.L. 109–171) added a new Medicaid state option for alternative premiums and cost-sharing for certain subgroups. Applicable maximum amounts vary by income level (as a percent of the federal poverty level). Special rules apply to prescription drugs and to non-emergency services provided in hospital emergency rooms.

Indians are not explicitly exempted from cost-sharing and premium charges in Medicaid. When an Indian Medicaid beneficiary receives services from a contract health services (CHS) provider, Medicaid pays for the service. Any copayment that Medicaid does not pay must be paid by the Indian Health Service (IHS) or the Tribe from its CHS budget, since the CHS provider may not bill the Indian patient. The practical effect of this is simply to reduce the amount of appropriated funds available for health care from IHS or CHS for Tribes that already lack sufficient resources. CHIP programs are already prohibited from imposing cost-sharing on eligible Indians.

Eligibility Determinations under Medicaid and CHIP. The federal Medicaid statute defines more than 50 eligibility pathways. For some pathways, states are required to apply an assets test. For other pathways, assets tests are a state option. When assets tests apply, some pathways give states flexibility to define specific assets that are to be counted and which can be disregarded. For other pathways, primarily for people qualifying on the basis of having a disability or who are elderly, assets tests are required. States generally follow asset guidelines specified for the Supplementary Security Income (SSI) program. Medicaid also defines the rules for the counting of certain assets. Under SSI law, several types of assets are excluded, including: (1) any land held in trust by the United States for a member of a federally-recognized tribe, or any land held by an individual Indian or tribe and which can only be sold, transferred, or otherwise disposed of with the approval of other individuals, his or her tribe, or an agency of the federal government; and (2) certain distributions (including land or an interest in land) received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation pursuant to the Alaska Native Claims Settlement Act. Most other property is required to be counted. There is no similar provision in current CHIP law.

Estate Recovery. The Omnibus Budget Reconciliation Act of 1993 requires all states to recover ; property and assets of deceased Medicaid beneficiaries for the cost of certain services provided by Medicaid. At a minimum, states must seek recovery for certain services provided, including nursing home care, services provided by an intermediate care facility for the mentally retarded or other similar medical institutions, and Medicaid payments to Medicare for cost-sharing related benefits. The state has discretion to recover further assets to cover the costs for all Medicaid services provided to the beneficiary. The state also has the authority to grant an exemption if the recovery would place undue hardship against the estate. The Secretary specifies the standards for a state hardship waiver for Medicaid estate recovery purposes.

HOUSE BILL

Premiums and Cost Sharing. The provision would specify that no enrollment fee, premium or similar charge, and no deduction, co-payment, cost-sharing, or similar charge shall be imposed against an Indian who receives Medicaid-coverable services or items directly from the Indian Health Service (IHS), an Indian Tribe (IT), Tribal Organization (TO), or Urban Indian Organization (UIO), or through referral under the contract health services (CHS) program. In addition, Medicaid payments due to the IHS, an IT, TO, or UIO, or to a health care provider through referral under the CHS program for providing services to a Medicaid-eligible Indian, could not be reduced by the amount of any enrollment fee, premium or similar charge, as well as any cost-sharing or similar charge that would otherwise be due from an

Indian, if such charges were permitted. A rule of construction would specify that nothing in this provision could be construed as restricting the application of any other limitations on the imposition of premiums or cost-sharing that may apply to a Medicaid-enrolled Indian. This language would also add Indians receiving services through Indian entities to the list of individuals exempt from paying premiums or cost-sharing under the DRA option for alternative premiums and cost-sharing under Medicaid. The effective date of this provision would be October 1, 2009.

Eligibility Determinations under Medicaid and CHIP. The provision would prohibit consideration of four different classes of property from resources in determining Medicaid eligibility of an Indian. These classes include: (1) property, including real property and improvements, that is held in trust (subject to federal restrictions or otherwise under the supervision of the Secretary of the Interior), located on a reservation, including any federally recognized Indian Tribes reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act (ANCSA), and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs; (2) for any federally recognized Tribe not described in the first class, property located within the most recent boundaries of a prior federal reservation; (3) ownership interests in rents, leases, royalties, or usage rights related to natural resources, including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish, resulting from the exercise of federally protected rights; and (4) ownership interest in or usage rights to items not covered in the previous classes that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law or custom. This provision is modeled on the provisions of the Centers for Medicare & Medicaid Services (CMS) State Medicaid Manual that exempt the same type of Indian property from Medicaid estate recovery. The House bill would also apply this new language to CHIP in the same manner in which it applies to Medicaid.

Estate Recovery. The provision would provide that certain income, resources, and property would remain exempt from Medicaid estate recovery if they were exempted under Section 1917(b)(3) of the Social Security Act (allowing the Secretary to specify standards for a state hardship waiver of asset criteria) under instructions regarding Indian tribes and Alaskan Native Villages as of April 1, 2003. The provision also would allow the Secretary to provide for additional estate recovery exemptions for Indians under Medicaid.

SENATE BILL

Same as House bill, except that these provisions would sunset on December 31, 2010. The Senate bill did not specify an effective date for the premiums and cost sharing provision, meaning those provisions would take effect upon enactment.

CONFERENCE AGREEMENT

The conference agreement follows the Senate bill with modifications for the provisions to be permanently effective July 1, 2009.

SEC. 5006(D). RULES APPLICABLE UNDER MEDICAID AND CHIP TO MANAGED CARE ENTITIES WITH RESPECT TO INDIAN ENROLLEES AND INDIAN HEALTH CARE PROVIDERS AND INDIAN MANAGED CARE ENTITIES (SEC. 3302 OF THE SENATE BILL)

CURRENT LAW

Section 1903(m)(1) of Title XIX defines: (1) the term Medicaid managed care organization (MCO), (2) requirements regarding accessibility of services for Medicaid MCO beneficiaries vis-a-vis non-MCO Medicaid beneficiaries within the area served by the MCO; (3) solvency standards in general and specific to different types of organizations; and (4) the duties and functions of the Secretary with respect to the status of an organization as a Medicaid MCO.

Section 1905(t) of Title XIX defines another type of managed care arrangement called primary care case management (PCCM). Under such arrangements, states contract with primary care case managers who are responsible for locating, coordinating and monitoring covered primary care (and other services stipulated in contracts) provided to all individuals enrolled in such PCCM programs.

Title XIX contains a number of additional provisions regarding managed care under Medicaid. Section 1932(a)(5) specifies rules regarding the provision of information about managed care to beneficiaries and potential enrollees. Such information must be in an easily understood form, and must address the following topics: (1) who providers are and where they are located, (2) enrollee rights and responsibilities, (3) grievance and appeal procedures, (4) covered items and services, (5) comparative information for available MCOs regarding benefits, cost-sharing, service area and quality and performance, and (6) information on benefits not covered under managed care arrangements. In addition, Section 1932(d)(2)(B) requires managed care entities to distribute marketing materials to their entire service areas.

Sections 1903(m) and 1932 provide cross-referencing definitions for the term ''Medicaid managed care organization.'' Under Title XIX, section 1932(a)(2)(C) stipulates the rules regarding Indian enrollment in Medicaid managed care. A state may not require an Indian (as defined in Section 4(c) of the Indian Health Care Improvement Act (IHCIA) to enroll in a managed care entity unless the entity is one of the following (and only if such entity is participating under the plan): (1) the IHS, (2) an IHP operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS pursuant to the Indian Self-Determination Act, or (3) an urban IHP operated by a UI0 pursuant to a grant or contract with the IHS pursuant to Title V of IHCIA.

In general, Federally Qualified Health Centers (FQHCs) are paid on a per visit basis, using a prospective payment system that takes into account costs incurred and changes in the scope of services provided. Per visit payment rates are also adjusted annually by the Medicare Economic Index applicable to primary care services. When an FQHC is a participating provider with a Medicaid managed care entity (MCE), the state must make supplemental payments to the center in an amount equal to any difference between the rate paid by the MCE and the per visit amount determined under the prospective payment system.

HOUSE BILL

No provision.

SENATE BILL

Under this provision, Medicaid managed care contracts with Managed Care Entities (MCEs) and Primary Care Case Management (PCCMs) companies would be required to meet certain conditions relating to access for Indian Medicaid beneficiaries in order to receive Medicaid payments, including:

MCEs and PCCMs would need to demonstrate that the number of participating Indian health care providers was sufficient to ensure timely access to covered Medicaid managed care services for eligible enrollees, and

MCEs and PCCMs would need to agree to pay Indian health care providers (IHPs) at rates equal to the rates negotiated between these organizations and the provider involved, or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the MCE or PCCM would make for services rendered by a participating non-Indian health care provider.

In addition, this provision would specify that MCEs and PCCMs must agree to make prompt payment, as required under Medicaid rules for all providers, to participating Indian health care providers, and states would be prohibited from waiving requirements relating to assurance that payments are consistent with efficiency, economy, and quality.

Further, this provision would apply special payment provisions to certain Indian health care providers that are Federally Qualified Health Centers (FQHCs). For non-participating Indian FQHCs that provide covered Medicaid managed care services to Indian MCE enrollees, the MCE must pay a rate equal to the payment that would apply to a participating non-Indian FQHC. When payments to such participating and non-participating providers by an MCE for services rendered to an Indian enrollee with the MCE are less than the rate under the state plan, the state must pay such providers the difference between the rate and the MCE payment. Likewise, if the amount, paid to a non-FQHC Indian provider (whether or not the provider participates with the MCE) is less than the rate that applies under the state plan, the state must pay the difference between the applicable rate and the amount paid by MCEs. Under this provision, Indian Medicaid MCEs would be permitted to restrict enrollment to Indians and to members of specific tribes in the same manner as IHPs may restrict the delivery of services to such Indians and tribal members.

Finally, the provision would apply specific sections affecting Medicaid to the CHIP program, including (1) Section 1932(a)(2)(C) in current law regarding enrollment of Indians in Medicaid managed care (e.g., states cannot require Indians to enroll in a MCE unless the entity is the IHS, certain IHPs operated by tribes or tribal organizations, or certain urban IHPs operated by Urban Indian Organizations (UIOs), and (2) the new Section 1932(h) as described above.

CONFERENCE AGREEMENT

The conference agreement follows the Senate bill with a modification deleting the sunset date clarifying that Indian Medicaid MCEs would be permitted to restrict enrollment to Indians but not to members of specific tribes, and clarifying access standards in states where there are no Indian providers. The provision would be effective July 1, 2009.

SEC. 5006(e). CONSULTATION ON MEDICAID, CHIP, AND OTHER HEALTH CARE PROGRAMS FUNDED UNDER THE SOCIAL SECURITY ACT INVOLVING INDIAN HEALTH PROGRAMS AND URBAN INDIAN ORGANIZATIONS (SEC. 5005 OF THE HOUSE BILL; SEC. 3303 OF THE SENATE BILL)

CURRENT LAW

There are no provisions in current Medicaid or CHIP statutes regarding a Tribal Technical Advisory Group (TTAG) within the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicare, Medicaid and CHIP programs. CMS currently maintains a TTAG for consultation on matters relating to Indian health care, but it is not codified in law.

HOUSE BILL

The provision would require the Secretary to maintain within CMS a Tribal TAG, previously established in accordance with requirements of a charter dated September 30, 2003. The provision also would require that the TAG include a

representative of the UI0s and IHS. The UI0 representative would be deemed an elected official of a tribal government for the purposes of applying Section 204(b) of the Unfunded Mandates Reform Act of 1995, which exempts elected tribal officials from the Federal Advisory Committee Act for certain meetings with federal officials.

The provision would also require states in which one or more IHPs or UI0s provide health services to establish a process for obtaining advice on a regular, on-going basis from designees of IHPs and UI0s regarding Medicaid law and its direct effects on those entities. This process must include seeking advice prior to submission of state Medicaid plan amendments, waiver requests or proposed demonstrations likely to directly affect Indians, IHPs, or UI0s. This process may include appointment of an advisory panel and of a designee of IHPs and UI0s to the Medicaid medical care advisory committee advising the state on its state Medicaid plan. The provision would also apply this new language to CHIP in the same manner in which it applies to Medicaid. Finally, the provision would prohibit construing these amendments as superseding existing advisory committees, working groups, guidance or other advisory procedures established by the Secretary or any state with respect to the provision of health care to Indians.

SENATE BILL

This provision is similar to the House provision. Both versions would require the Secretary to maintain within CMS a Tribal Technical Advisory Group (TTAG), previously established in accordance with requirements of a charter dated September 30, 2003. The provision also would require that the TTAG include a IHS representative. Unlike the House bill, however, under this provision in S.Amdt. 570, the TTAG also would include a representative of a national urban Indian Health organization, rather than a representative of the UI0s. The non-application of Federal Advisory Committee Act (FACA) would still hold for a representative of a national UIO.

CONFERENCE AGREEMENT

The conference agreement follows the Senate bill with a modification deleting the sunset date. The provision would be effective July 1, 2009.

SEC. 5007. FUNDING FOR OVERSIGHT AND IMPLEMENTATION (SEC. 5004 OF THE SENATE BILL)

CURRENT LAW

The Office of Inspector General (OIG) of the Department of Health and Human Services is responsible for ensuring program integrity of over 300 programs in the Department, including the Medicaid program. The OIG's program integrity activities are funded through a combination of discretionary appropriations and mandatory funding through the Health Care Fraud and Abuse Control Program. The Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services administers the Medicaid program at the federal level. These administrative activities are funded through discretionary appropriations.

HOUSE BILL

No provision.

SENATE BILL

Under this provision, the Health and Human Services Office of the Inspector General (HHS OIG) is to receive $31.25 million to ensure the proper expenditure of federal Medicaid funds. These funds are appropriated from any money in the Treasury not otherwise appropriated and are available throughout the recession period (defined as October 1, 2008 through December 31, 2010). Amounts appropriated under this provision would be available until September 30, 2012, without further appropriation, and would be in addition to any other amounts appropriated or made available to HHS OIG.

CONFERENCE AGREEMENT

The conference agreement follows the Senate bill with a modification. The funds for the HHSOIG would be appropriated in FY2009 and would be available for expenditure until September 30, 2011. The conference agreement would also appropriate $5 million in FY2009 to CMS for the implementation and oversight of the state fiscal relief provisions relating to Medicaid. These funds would remain available until expended.

SEC. 5008. GAO STUDY AND REPORT REGARDING STATE NEEDS DURING PERIODS OF NATIONAL ECONOMIC DOWNTURN (SEC. 5005 OF THE SENATE BILL)

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE BILL

Under this provision, the Comptroller General of the United States, would study the current (as of the date of enactment of the legislation) economic recession as well as previous national economic downturns since 1974. GAO would develop recommendations to address states' needs during economic recessions, including the past and projected effects of temporary increases in the federal medical assistance percentage (FMAP) during these recessions. By April 1, 2011, GAO would submit a report to appropriate congressional committees that would include the following:

Recommendations for modifying the national economic downturn assistance formula for temporary Medicaid FMAP adjustments (a ''countercyclical FMAP,'' as described in GAO report number, GAO–07–97), to improve the effectiveness of the countercyclical FMAP for addressing states' needs during national economic downturns:

- what improvements are needed to identify factors to begin and end the application of a countercyclical FMAP;
- how to adjust the amount of a countercyclical FMAP to account for state and regional variations; and
- how a countercyclical FMAP could be adjusted to better account for actual Medicaid costs incurred by states during economic recessions.
- Analysis of the impact on states of recessions, including declines in private health insurance benefits coverage; declines in state revenues; and maintenance and growth of caseloads under Medicaid, CHIP, or any other publicly funded programs that provide health benefits coverage to state residents.

CONFERENCE AGREEMENT

The conference agreement follows the Senate bill.

PAYMENT OF MEDICARE LIABILITY TO STATES AS A RESULT OF THE SPECIAL DISABILITY WORKLOAD PROJECT (SEC. 5003 OF THE SENATE BILL)

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE BILL

Under this provision, within three months after enactment of this law, the Secretary, in consultation with the Commissioner of Social Security, would negotiate an agreement on a payment amount to be made to each state for the Medicare Special Disability Workload (SDW) project. Payments to states would be subject to certain conditions:

- states would waive the right to file or be a part of any civil action in any federal or state court where payment was sought for liability related to the Medicare SDW project;
- states would release the federal government from any further claims for reimbursement of state expenditures arising from the SDW project;
- states that are parties to civil actions in any federal or state court seeking reimbursement for the SDW project, would be ineligible to receive payment under this provision while such action is pending or if it is resolved in a state's favor.

In negotiating with states, the Secretary and SSA Commissioner would use the most recent federal data available, including estimates, to determine the amount of payment to be offered to each state that elects to enter into an agreement with the Secretary. The payment methodology would consist of the following factors:

- the number of SDW cases that were eligible for benefits under Medicare and the month when these cases initially became eligible;
- the applicable non-federal share of Medicaid expenditures made by states during the period these cases were eligible; and
- other factors determined appropriate by the Secretary and the SSA Commissioner in consultation with states.

However, as a condition of payment under a negotiated agreement for SDW cases, states would not be required to submit individual paid Medicaid claims data.

To make payments to states for the SDW project, $3 billion would be appropriated for FY2009 from money in the treasury not otherwise appropriated. Aggregate payments to states could not exceed $3 billion. Payments to states would be provided within four months from the date of enactment of ARRA.

An SDW case would be defined as an individual determined by the SSA Commissioner to have been eligible for benefits under Title II of the SSA for a period during which such benefits were not provided to the individual and who was, during all or part of such period, enrolled in Medicaid.

CONFERENCE AGREEMENT

The conference agreement follows the House bill.

DIVISION B

TITLE VI—BROADBAND TECHNOLOGY OPPORTUNITIES PROGRAM

HOUSE BILL

Section 6001 of the House bill directs the National Telecommunications and Information Administration (''NTIA'') to develop and maintain a broadband inventory map of the United States that identifies and depicts broadband service availability and capability and directs the NTIA to make the map accessible on the NTIA's website no later than 2 years after the date of enactment of this Act. It authorizes the creation of grant programs for the deployment of wireless and wireline broadband infrastructure to be administered by the NTIA. It also authorizes a state to submit a priority report to the NTIA that identifies the geographic areas within that state that have greatest need for new or additional telecommunications infrastructure. A state may not identify areas encompassing more than 20% of that state's population.

Section 6002 of the House bill authorizes the NTIA to award wireless deployment grants and broadband deployment grants to eligible entities for the non-recurring costs of deploying broadband infrastructure in qualified urban, suburban, and rural areas. Section 6002 directs the NTIA to seek to distribute wireless grants, to the extent possible, so that 25% of the available funds go to ''unserved areas'' for basic wireless voice services and 75% to ''underserved areas'' for advanced wireless broadband services. It also directs that the NTIA shall seek to distribute broadband deployment grants, to the extent possible, so that 25% of the available funds go to ''unserved areas'' for basic broadband services and 75% to ''underserved areas'' for advanced broadband services. Section 6002 directs the NTIA to establish certain grant requirements, including that

grant recipients are not unjustly enriched by the program, adhere to the FCC's August 5, 2005, broadband internet policy statement, operate networks on an open access basis, and adhere to a build out schedule.

Section 6002 of the House bill sets forth the requirements of the grant application and grant selection criteria. The NTIA is required to consider certain public policy goals (e.g., public safety benefits and enhancement of computer ownership or literacy) before awarding grants. It requires the NTIA to coordinate with the FCC and to consult with other agencies as necessary. Section 6002 requires the NTIA to submit an annual report to Congress assessing the impact of the grants on the policy objectives and criteria contained in this Section and grants the NTIA authority to prescribe rules as necessary to implement this Section. Section 6002 also contains definitions of terms used in this Section, and directs the FCC to develop definitions for the terms unserved, underserved, and open access.

Section 6002 defines ''basic broadband service'' as a service delivering data to the end user at a speed of at least 5 megabits per second downstream and 1 megabit per second upstream. The term ''advanced broadband service'' means a service capable of delivering at least 45 megabits per second downstream and 15 megabits per second upstream. The term advanced wireless broadband service means a service capable of delivering at least 3 megabits downstream and 1 megabit upstream.

Section 6003 of the House bill requires the FCC to, not later than one year after the date of enactment of this section, develop and submit to Congress a report containing a national broadband plan and specifies what the plan should include.

SENATE BILL

Section 201 of the Senate bill authorizes the NTIA to create a grant program entitled the Broadband Technology Opportunity Program to award competitive grants to State and local governments, nonprofits, and public-private partnerships to: (1) accelerate broadband deployment in unserved and underserved areas and to strategic institutions that are likely to create jobs or provide significant public benefits; (2) increase sustained broadband adoption; and (3) upgrade technology and capacity for public safety entities and at public computing centers, which are a key source of access to the Internet for lower income users, such as libraries and community colleges.

Section 201 gives the NTIA the authority to impose grant conditions with regard to interconnection and nondiscrimination requirements that apply to facilities funded in part by this program, regardless of who operates those facilities.

Section 201 also (1) imposes a 20 percent match requirement for grants, which may be satisfied by the grant applicant or any third-party partnering with the grant applicant, and may be waived only under special circumstances; (2) requires specific commitments from grantees on scheduled progress for meeting the goals of the grant; (3) requires that grant applications show that the proposed broadband deployment would not occur during the grant period without this Federal investment; (4) requires quarterly reporting by any entity receiving funds regarding how funds are spent and progress meeting the schedule, as well as quarterly reporting to Congress by Federal agencies making grants regarding how funds are being spent; (5) requires strong public transparency regarding how funds are spent under the program and grantees' progress fulfilling specific commitments to deploy facilities, increase broadband adoption or deploy computer infrastructure; and (6) empowers the NTIA to revoke funding in any case of misspending, and to recapture funds in certain circumstances.

CONFERENCE AGREEMENT

Summary

The Conference substitute retains the general structure and language of the Senate bill, while incorporating a series of amendments related to the priorities of the House.

Section 6001. Section 6001 establishes the Broadband Technology Opportunities Program within the NTIA. The Conferees intend that the NTIA has discretion in selecting the grant recipients that will best achieve the broad objectives of the program. The Conferees also intend that the NTIA select grant recipients that it judges will best meet the broadband access needs of the area to be served, whether by a wireless provider, a wireline provider, or any provider offering to construct last-mile, middle-mile, or long haul facilities. The Conferees intend that the NTIA award grants serving all parts of the country, including rural, suburban, and urban areas. The Conferees intend that the NTIA seek to ensure, to the extent practicable, that grant funds be used to assist infrastructure investments that would not otherwise be made by the entity applying, or, secondarily, that might not be made as quickly.

Part of the program is directed towards competitive grants for innovative programs to encourage sustainable adoption of broadband service in particular by vulnerable populations. The Conferees note the success of such programs in several States, and hope that these grantees will be involved in aggregating demand, ensuring community involvement, and fostering useful technology applications, thereby stimulating economic growth and job creation.

Eligible Entities. The Conference substitute creates a new, broad definition of entities that are eligible to receive grants. It is the intent of the Conferees that, consistent with the public interest and purposes of this section, as many entities as possible be eligible to apply for a competitive grant, including wireless carriers, wireline carriers, backhaul providers, satellite carriers, public private partnerships, and tower companies.

Grant Distribution Considerations and Broadband Speeds. The Conference substitute inserts a new Section 6001(h) that incorporates several of the grant distribution considerations from the House bill. In particular, new Section 6001(h)(3) requires the NTIA to consider whether a grant applicant is a socially and economically disadvantaged small business, as defined under the Small Business Act.

New Section 6001(h)(2)(*Bb*) also requires the NTIA to consider whether an application will result in the greatest possible broadband speeds being delivered to consumers. While the House bill had included specific speed thresholds that an applicant must have met to be eligible for a grant, the substitute requires only that the NTIA consider the speeds that would be delivered to consumers in awarding grants. The Conferees are mindful that a specific speed threshold could have the unintended result of thwarting broadband deployment in certain areas. The Conferees are also mindful that the construction of broadband facilities capable of delivering next-generation broadband speeds is likely to result in greater job creation and job preservation than projects centered on current-generation broadband speeds. Therefore, the Conferees instruct the NTIA to seek to fund, to the extent practicable, projects that provide the highest possible, next-generation broadband speeds to consumers.

Broadband Policy Statement. The Conference substitute inserts the House language that requires grant recipients to adhere to the principles contained in the Federal Communications Commission's Broadband Policy Statement.

National Broadband Plan. The Conference substitute adopts the House language on the creation of a national broadband plan, with some minor modifications.

Federal/State Cooperation. Section 6001(c) directs the NTIA to consult with States on: (1) the identification of unserved and underserved areas within their borders; and (2) the allocation of grants funds to projects affecting each State. The Conferees recognize that States have resources and a familiarity with local economic, demographic, and market conditions that could contribute to the success of the broadband grant program. States are encouraged to coalesce stakeholders and partners, assess community needs, aggregate demand for services, and evaluate demand for technical assistance. The Conferees therefore expect and intend that the NTIA, at its discretion, will seek advice and assistance from the States in reviewing grant applications, as long as the NTIA retains the sole authority to approve the awards. The Conferees further intend that the NTIA will, in its discretion, assist the States in post-grant monitoring to ensure that recipients comply fully with the terms and conditions of their grants.

Definitions. The substitute does not define such terms as ''unserved area'' ''underserved areas'' and ''broadband.'' The Conferees instruct the NTIA to coordinate its understanding of these terms with the FCC, so that the NTIA may benefit from the FCC's considerable expertise in these matters. In defining ''broadband service,'' the Conferees intend that the NTIA take into consideration the technical differences between wireless and wireline networks, and consider the actual speeds that broadband networks are able to deliver to consumers under a variety of circumstances.

TITLE VII—LIMITS ON EXECUTIVE COMPENSATION

A. Executive Compensation Oversight (Secs. 6001 to 6006 of the Senate Amendment and Sec. 7001 of the Conference Agreement)

PRESENT LAW

An employer generally may deduct reasonable compensation for personal services as an ordinary and necessary business expense. Section 162(m) (relating to remuneration expenses for certain executives that are in excess of $1 million) and section 280G (relating to excess parachute payments) provide explicit limitations on the deductibility of certain compensation expenses in the case of corporate employers, and section 4999 imposes an additional tax of 20 percent on the recipient of an excess parachute payment. The Emergency Economic Stabilization Act of 2008 (''EESA'') limits the amount of payments that may be deducted as reasonable compensation by certain financial institutions (''TARP recipients'') that receive financial assistance from the United States pursuant to the troubled asset relief program (''TARP'') established under EESA by modifying the section 162(m) and section 280G limits. EESA also provided non-tax rules relating to the compensation that is payable by such a financial institution (the ''TARP executive compensation rules'').

HOUSE BILL

No provision.

SENATE AMENDMENT

The provision modifies and expands the present law non-tax TARP executive compensation rules. The modifications include: (1) expanding the requirement of recovery of a bonus, retention award, or incentive compensation paid to a senior executive officer

based on statements of earnings, revenues, gains, or other criteria that are found to be materially inaccurate to the next 20 most highly compensated employees of a TARP recipient; (2) expanding the prohibition on the payment of golden parachute payments from senior executive officers to the next five most highly compensated employees of the TARP recipient, and defining the term ''golden parachute payment'' as any payment to a senior executive officer for departure from a company for any reason, except for payments for services performed or benefits accrued; and (3) prohibiting a TARP recipient from paying or accruing any bonus, retention award, or incentive compensation to at least the 25 most highly compensated employees; and (4) prohibiting any compensation plan that would encourage manipulation of the reported earnings of a TARP recipient to enhance the compensation of any of its employees. The provision also provides rules relating to the compensation committees of TARP recipients, nonbinding shareholder votes on executive compensation payable by a TARP recipient, and the adoption by TARP recipients of policies regarding luxury expenditures such as entertainment, aviation, and office renovation expenses.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment with several modifications. Among the modifications are (1) a rule that provides that financial assistance under TARP is not treated as outstanding for a period in which the United States only holds warrants to purchase common stock of the TARP recipient; (2) rules that phase-in the restriction on bonuses, retention awards, and other incentive compensation by the amount of financial assistance received by the entity receiving TARP assistance, and that permit compensation to be paid in the form of restricted stock; and (3) and a directive to the Secretary of the Treasury to review compensation paid to senior executive officers and the next 20 most highly compensated employees of an entity receiving TARP assistance before the date of enactment to determine whether such payments were inconsistent with the provision, the TARP, or public interest.

TAX COMPLEXITY ANALYSIS

Section 4022(b) of the Internal Revenue Service Reform and Restructuring Act of 1998 (the ''IRS Reform Act'') requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses. For each such provision identified by the staff of the Joint Committee on Taxation a summary description of the provision is provided along with an estimate of the number and type of affected taxpayers, and a discussion regarding the relevant complexity and administrative issues.

Following the analysis of the staff of the Joint Committee on Taxation are the comments of the IRS and Treasury regarding each of the provisions included in the complexity analysis.

1. MAKE WORK PAY CREDIT

SUMMARY DESCRIPTION OF THE PROVISION

The provision creates a refundable tax credit for taxable years beginning in 2009 and 2010 equal to the lesser of (1) 6.2 percent of an individual's earned income or (2) $400 ($800 in the case of a joint return). The credit is phased out at a rate of two percent of the eligible individual's modified adjusted gross income above $75,000 ($150,000 in the case of a joint return).

NUMBER OF AFFECTED TAXPAYERS

It is estimated that the provision will affect in excess of 100 million individual tax returns.

DISCUSSION

The provision will require additional paperwork for taxpayers and additional processing burdens for IRS. It is expected that taxpayers will need to complete additional worksheets and or forms to compute the amount of the credit. Taxpayers may also wish to adjust their income tax withholding by filing the appropriate forms before the end of 2009. The IRS is anticipated to revise income tax withholding schedules and publish new schedules. These revised income tax withholding schedules should be designed to reduce taxpayers' income tax withheld for each remaining pay period in the remainder of 2009 so that the full benefit of the provision is reflected in the income tax withholding schedules during the balance of 2009.

2. EXTENSION OF ALTERNATIVE MINIMUM TAX RELIEF FOR INDIVIDUALS

SUMMARY DESCRIPTION OF THE PROVISION

The provision increases the individual AMT exemption amount for taxable years beginning in 2009 to $70,950 in the case of married individuals filing a joint return and surviving spouses; $46,700 in the case of other unmarried individuals; and $35,475 in the case of married individuals filing separate returns. In addition, for taxable years beginning in 2009, the provision allows an individual to offset the entire regular tax liability and alternative minimum tax liability by the nonrefundable personal credits.

NUMBER OF AFFECTED TAXPAYERS

It is estimated that the provision will affect approximately 25 million individual tax returns.

DISCUSSION

Many individuals will not have to compute their alternative minimum tax and file the IRS forms relating to that tax.

3. SPECIAL ALLOWANCE FOR CERTAIN PROPERTY ACQUIRED DURING 2009

SUMMARY DESCRIPTION OF THE PROVISION

The provision extends the additional first-year depreciation deduction for one year, generally through 2009 (through 2010 for certain longer-lived and transportation property).

NUMBER OF AFFECTED TAXPAYERS

It is estimated that more than 10 percent of small businesses will be affected by the provision.

DISCUSSION

It is not anticipated that small businesses will have to keep additional records due to this provision, nor will additional regulatory guidance be necessary to implement this provision. It is not anticipated that the provision will result in an increase in disputes between small businesses and the IRS. However, small businesses will have to perform additional analysis to determine whether property qualifies for the provision. In addition, for qualified property, small businesses will be required to perform additional calculations to determine the proper amount of allowable depreciation. Complexity may also be increased because the provision is temporary. For example, different tax treatment will apply for identical equipment based on the acquisition and placed in service date. Further, the Secretary of the Treasury is expected to have to make appropriate revisions to the applicable depreciation tax forms.

4. PREMIUM ASSISTANCE FOR COBRA BENEFITS

SUMMARY DESCRIPTION OF THE PROVISION

The provision reimburses employers providing COBRA continuation health coverage to employees to the extent of 65 percent of the premium amount for up to nine months and requires the eligible individual to pay 35 percent of the premium. The program is mandatory for employers required to offer COBRA continuation health coverage. Eligible individuals must have a qualifying event between September 1, 2008 and December 31, 2009, and must have been terminated involuntarily. Firms providing COBRA benefits will be able to allow those electing COBRA to choose from other insurance options at the time of the qualifying event, and firms will be able to contribute to the individual portion of the premium. Lastly, the benefit phases out for single taxpayers with modified adjusted gross incomes between $125,000 and $145,000 ($250,000 and $290,000 for joint filers) for the taxable year.

Employers will pay reduced payroll taxes in the aggregate amount of 65 percent of the premium for all individuals who opt into the provision, or, if COBRA subsidy exceeds payroll taxes, employers will be reimbursed directly through a program established by the Department of Treasury. COBRA continuation health coverage for this purpose includes not only coverage that applies to private, nongovernmental employers with 20 or more employees but also coverage rules that apply to Federal and State and local governmental employers pursuant to Federal law, and to State law mandates that apply to small employers (employers with less than 20 employees) and other employers not covered by Federal law, provided that such State law mandates require an employer or other entity to offer comparable continuation health coverage. The social security trust fund is held harmless from payroll tax offsets that are permitted under the program.

NUMBER OF AFFECTED TAXPAYERS

It is estimated that more than 10 percent of small businesses will be affected by the provision.

DISCUSSION

This provision will require additional processing by the IRS in three areas; accounting, income eligibility and provision enforcement. First, for all firms with eligible employees, the firm must deduct that amount from their payroll taxes, so IRS must be aware of the number of employees eligible for the reimbursement and the average monthly premium at the firm to properly assess the amount of the deduction from payroll taxes. The Department of Treasury must then transfer the appropriate amount of funds back into the social security trust fund. All employers bound by COBRA or COBRA-type legislation described above, and who terminate individuals from employment between September 1, 2008, and December 31, 2009, are affected by this provision. In addition, firms are permitted to collect full premiums from individuals for 60 days in accordance with their current premium billing cycles, but must then credit back the difference in later payments or if later payments are insufficient to credit back all funds, the employer will submit payment to the individual. The IRS must also distinguish between the 65 percent of subsidy contribution mandated and any optional firm contribution to the remaining 35 percent of premium.

Second, the income eligibility provision in the bill limits eligibility for the modified adjusted gross income limit of the provision

phasing out between $125,000 and $145,000 for single filers ($250,000 and $290,000 for joint filers) for the taxable year. While individuals may waive the subsidy if they believe their earnings will exceed the limit, if an individual accepts the subsidy and earns over the limit the individual will be responsible for paying the subsidy back to Treasury. For married individuals filing separately, if any family member is over the single modified adjusted gross income limit of $125,000, the entire non-subsidized portion (this accounts for the phase out) must be repaid. This clause requires IRS to match the incomes of spouses filing separately and determine if the modified adjusted gross income of either spouse disqualifies both for the subsidy received. Children not claimed as dependents, however, who are still on family plans have their incomes excluded from this limitation.

Third, the IRS must create rules and regulations to prevent fraud and abuse of this provision. For example, taxpayers may be required to provide evidence of eligibility for the subsidy including evidence of involuntary separation from work, which can include attestation from the former employer or certification from state unemployment insurance agencies. If a premium assistance eligible individual becomes eligible for other group coverage while receiving premium assistance, that individual must forfeit the subsidy or face a penalty and the IRS must attempt to prevent individuals from claiming the subsidy while eligible for other group coverage either through a spouse or through a new employer.

COMPLIANCE WITH CLAUSE 9 OF RULE XXI (EARMARKS)

Pursuant to clause 9 of rule XXI of the Rules of the House of Representatives, neither this conference report nor the accompanying joint statement of managers contains any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(e), 9(f), or 9(g) of rule XXI.

DAVID OBEY,
CHARLES RANGEL,
HENRY WAXMAN,
Managers on the Part of the House.

DANIEL K. INOUYE,
MAX BAUCUS,
HARRY REID,
Managers on the Part of the Senate.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 10 o'clock and 26 minutes p.m.), the House stood in recess subject to the call of the Chair.

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AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. PERLMUTTER) at 12 o'clock and 1 minute a.m.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF CONFERENCE REPORT ON H.R. 1, AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

Mr. POLIS of Colorado, from the Committee on Rules, submitted a privileged report (Rept. No. 111–17) on the resolution (H. Res. 168) providing for consideration of the conference report to accompany the bill (H.R. 1) making supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, and State and local fiscal stabilization, for the fiscal year ending September 30, 2009, and for other purposes, which was referred to the House Calendar and ordered to be printed.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. ISRAEL) to revise and extend their remarks and include extraneous material:)

Ms. ROYBAL-ALLARD, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Mr. HOLT, for 5 minutes, today.

(The following Members (at the request of Mr. ROE of Tennessee) to revise and extend their remarks and include extraneous material:)

Mr. PAUL, for 5 minutes, today and February 13.

Mr. PENCE, for 5 minutes, today.

Mr. BROUN of Georgia, for 5 minutes, today.

Mr. ROE of Tennessee, for 5 minutes, today.

Mr. FRANKS of Arizona, for 5 minutes, today.

Mr. FORTENBERRY, for 5 minutes, today.

(The following Member (at her request) to revise and extend her remarks and include extraneous material:)

Ms. VELÁZQUEZ, for 5 minutes, today.

ADJOURNMENT

Mr. POLIS of Colorado. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 12 o'clock and 2 minutes a.m.), the House adjourned until today, Friday, February 13, 2009, at 9 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

569. A letter from the Deputy Under Secretary for Acquisition and Technology, Department of Defense, transmitting a report identifying each extension of a contract period to a total of more than 10 years that was granted under 10 U.S.C. 2304a(f) for the Department's task and delivery order contracts during fiscal year 2008, pursuant to Public Law 108-375, section 813; to the Committee on Armed Services.

570. A letter from the Principal Deputy Assistant Attorney General, Department of Justice, transmitting notification that the Department complies with the guidelines of the No FEAR Act; to the Committee on Oversight and Government Reform.

571. A letter from the Chairman and Chief Executive Officer, Farm Credit Administration, transmitting notification that the Administration is in compliance with the Government in Sunshine Act for calendar year 2008; to the Committee on Oversight and Government Reform.

572. A letter from the Chairman, International Trade Commission, transmitting the Commission's semiannual report from the office of the Inspector General for the period April 1, 2008 through September 30, 2008, pursuant to 5 U.S.C. app. (Insp. Gen. Act) section 5(b); to the Committee on Oversight and Government Reform.

573. A letter from the Attorney Advisor, Department of Homeland Security, transmitting the Department's final rule — Saftey Zone; Flagler Museum New Year's Eve Celebration fireworks display, West Palm Beach, Florida [Docket No.: USCG-2008-1120] (RIN: 1625-AA00) received February 2, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

574. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Airbus Model A318, A319, A320, and A321 Airplanes [Docket No.: FAA-2008-0558; Directorate Identifier 2007-NM-365-AD; Amendment 39-15783; AD 2009-01-04] (RIN: 2120-AA64) received January 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

575. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-2C10 (Regional Jet Series 700, 701, & 702) and Model CL-600-2D24 (Regional Jet Series 900) Airplanes [Docket No.: FAA-2008-0540; Directorate Identifier 2008-NM-031-AD; Amendment 39-15786; AD 2009-01-07] (RIN: 2120-AA64) received January 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

576. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Turbomeca Arriel 2B and 2B1 Turboshaft Engines [Docket No.: FAA-2008-0935; Directorate Identifier 2008-NE-28-AD; Amendment 39-15790; AD 2009-01-11] (RIN: 2120-AA64) received January 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

577. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 737-600,-700,-700C, -800 and -900 Series Airplanes [Docket No.: FAA-2007-28283; Directorate Identifier 2006-NM-254-AD; Amendment 39-15780; AD 2009-01-02] (RIN: 2120-AA64) received January 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

578. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Polskie Zaklady Lotnicze Spolka zo.o Model PZL M26 01 Airplanes [Docket No.: FAA-2009-0010; Directorate Identifier 2009-CE-001-AD; Amendment 39-15792; AD 2009-02-02] (RIN: 2120-AA64) received January 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

579. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model DHC-8-400 Series Airplanes [Docket No.: FAA-2008-1083; Directorate Identifier 2008-NM-130-AD;